9-14-01

Finance Working Group Report: The Lewin Report on Medicaid Payments to Hospitals and Related Issues

Summary

Over the last several weeks The Finance Group has met with the authors of The Lewin Report, analyzed the methodology of the report, and discussed the broader implications of its recommendations for the health care system of the Commonwealth. The Finance Group believes that the Lewin Report is a highly competent analysis and can serve as an important contribution to the state's understanding of the effects of its Medicaid payment policy on our health care system. Many of Lewin's recommendations are highly technical and relate to detailed aspects of the Medicaid payment formula. While we will touch on some aspects of these technical issues in this memo, we await the results of several studies being undertaken by the Medicaid program before presenting our final recommendations. For much of this memo, however, the Finance Group will focus on the broader context in which the Lewin Report should be viewed and considered.

The principal finding of the Lewin Report is that Massachusetts Medicaid pays most hospitals substantially less than the costs they incur providing care to Medicaid enrollees. In addition, the Report shows that Medicaid has covered a smaller portion of costs each year since 1997 – a period in which Medicare and private payers have also generally covered decreasing percentages of cost. As a consequence of the fact that none of the major payers covers the costs of care provided to its enrollees, aggregate hospital revenues for most hospitals in the state have not covered their costs and the overall financial position of our hospitals is among the worst in the country.

While a number of questions can and should be asked and answered about certain aspects of the Report – as outlined more fully below – the Finance Group believes that the situation the Report portrays could threaten many hospitals' continued viability. Widespread closures could, in turn, lead to a potentially dangerous situation for all Massachusetts citizens. For many hospitals, the increasing gap between Medicaid payments and costs contributes to the problem. The Finance Group believes that additional state funding should be devoted to the hospital system in light of this situation, but there is disagreement among Group members about the best way to distribute those funds. Several options are outlined below. The Finance Group also believes that broader public policy questions should be addressed as more far-reaching changes in health policy, including Medicaid payment policy and program features, are pursued. Additionally, and as a threshold matter, the Finance Group believes that certain features of the Massachusetts health care context are important to developing a full understanding of the Lewin Report and its implications.

Context

The Lewin Report's findings and recommendations about Medicaid hospital payments should be understood and considered in a broader context than the information contained in the Report itself. For example, according to Lewin's methodology, Massachusetts ranks among the lowest of the selected benchmark states in the *percentage of* "Medicaid cost" covered by its Medicaid hospital payments. While this is certainly a disturbing finding, the Report does not include a comparison of state Medicaid spending or how per-discharge cost levels in the state compare to other benchmark states. After consulting with the Finance Group, the Lewin staff provided information which showed that Massachusetts ranks fifth in the nation in overall Medicaid spending per enrollee, excluding long-term care spending, and seventh when long-term care spending is included. [See Attachment 1] This is true despite the fact that our enrollment is large and our eligibility is broad relative to many other states – which means our Medicaid program covers both low-cost and high-cost individuals (whereas some states with high per-enrollee spending could be covering only the highest-cost individuals). Put another way, the problem is not that Massachusetts is reluctant to spend on its Medicaid program.

In addition, the Medicaid payment-to-cost ratio Lewin identified for Massachusetts is about the same as or higher than that in four of the ten benchmark states Lewin selected. While that does not justify our ratio, it does demonstrate that Massachusetts is not an outlier with respect to its coverage of costs. [See Lewin Report Tables 1.1 & 1.2] The significance of the low Medicaid payment-to-cost ratio in Massachusetts is greater, however, because we are the only state in which none of the major payers is covering costs. The problem is therefore not only one of low Medicaid rates, but of low payments, in general, in relation to costs.

This general context is important because the Finance Group believes there should be broad recognition that the Massachusetts health care system has problems that extend well beyond the level of Medicaid rates. While state payment policy is important and deserves careful attention in this forum and others, issues relating to the aggregate cost and efficiency of our delivery system, utilization of services, and payment policies of other payers present problems that are at least as significant as Medicaid rates to the long-term stability of the system.[1] Medicaid rates are only a part of the problem, and increasing Medicaid payments alone cannot be viewed as a "solution." Because the immediate topic for discussion is the Lewin Report, this report focuses first on questions about the Lewin Report. It then outlines options for intervention in the short term. Finally, it addresses the broader issues the Finance Group believes need to be discussed and outlines several broad policy options for longer term change.

[1] While the Massachusetts Hospital Association argues that Medicaid represents a significant portion of the industry-wide shortfall between payments and costs, it remains true that Medicaid is only approximately 12% of hospitals' payer mix, on average.

Questions About the Lewin Study

The Lewin Report devoted considerable attention to the Medicaid payment-to-cost ratio. The Finance Group believes additional analysis of the "cost" side of that ratio is appropriate. For example, does the level of Medicaid "cost" change significantly when reported costs are allocated according to a method based on payer casemix, rather than the charge-based allocation method Lewin has used? Are there other methods of allocating hospital costs that should be considered? The Division of Health Care Finance and Policy is researching the answers to these questions, which will help determine how the gap between payments and costs should be allocated among Medicare, Medicaid and private payers under differing measures of "costs." In addition, Lewin recommended that Medicaid adopt payment methodologies similar or identical to those being used by the Medicare program. Before adopting that recommendation, the state should analyze how its adoption would change payment distributions, and whether those outcomes would further overall program goals. This is worth investigating because the populations covered by Medicare and Medicaid are very different, and it does not automatically follow that a sound methodology for Medicare's purposes will serve those of Medicaid equally well.

Information about cost allocation methods and the effects of adopting a Medicare-based approach will be useful in policymaking over time, but may not be required to evaluate whether certain of the Lewin recommendations should be implemented in the shorter term. For example, Lewin expressed limited concerns about the Medicaid inpatient payment methodology, the fundamental approach of which Lewin found to be sound (in contrast to the outpatient methodology, which Lewin found to be more fundamentally flawed). However, Lewin did recommend that the inflation factor be re-examined. The Lewin Report concluded that the state has adopted an unrealistic inflation adjustment which has, over time, restricted Medicaid payments to levels below reasonable cost. They therefore recommended that there be an immediate across-the-board increase in Medicaid payments to recognize inflation since the latest base year used to establish rates. Most members of the Finance Group concur with that recommendation, and believe that this feature of the payment methodology should be evaluated immediately and changed, notwithstanding lingering questions about some of the other Lewin recommendations as noted above.

The Finance Group found it difficult to evaluate certain aspects of Lewin's efficiency analysis, which is based on a model that predicts and compares costs, because the hospital by hospital details of the cost comparison model were not made available. Regardless of the accuracy of the aggregate efficiency analysis, the Finance Group believes that additional attention should be devoted to individual hospital-by-hospital analysis of cost, efficiency, and the Medicaid payment-to-cost ratio. This is necessary for several reasons. First, those hospitals that are comparatively efficient and low-cost may have best practices that would be useful to highlight for the rest of the industry. Second, the Medicaid program is legally mandated "to ensure that rates of payment to providers do not exceed such rates as are necessary to meet only those costs which must be incurred by efficiently and economically operated providers in order to provide services of

adequate quality."[2] In order to comply with this mandate as they consider changes in payment policy, Medicaid officials need to understand whether (and if so, why) the payment-to-cost ratio, under Lewin's analysis, may be high at hospitals that Lewin deems inefficient, or low at hospitals that Lewin deems efficient. Medicaid officials are working with Lewin to understand the individual hospital data that formed the basis of Lewin's aggregated findings. Finally, in order to determine how to maximize the impact of additional state dollars that might be devoted to Medicaid hospital payments, it is important to determine how the Lewin recommendations would affect individual hospitals' Medicaid payment-to-cost ratio and overall financial condition. Medicaid officials are researching this question. Questions about individual hospital cost, efficiency, payment-to-cost ratios and the effect of Lewin's recommendations should be answered before broader changes in Medicaid payment policy are finalized. (In contrast, Lewin recommendations that would be uniform in their effect, such as the recommendation that the inflation factor be reconsidered, may be evaluated without the analysis of hospital-by-hospital data.)

Finally, the Lewin Group's efficiency analysis focuses on Massachusetts hospitals' costs as compared with hospitals nationwide. The Finance Group believes that in order to inform policymaking with respect to Medicaid and the state's role in health care generally, analysis of the cost and efficiency of "the system" is required. For example, given the high dependence of Massachusetts on teaching hospitals, are aggregate reported hospital costs "reasonable" in relation to figures from other states? Are expenditures per person on hospital services across all payers in Massachusetts "reasonable" in relation to other states and the national average? How have Massachusetts' hospital costs and revenues changed over the last ten years, in comparison with hospitals nationally? The answers to these questions would further illuminate the dynamics at work in our health care system and would help state leaders determine whether to pursue certain policy options aimed at changing "the system" as we know it. The Division of Health Care Finance and Policy is working with the Finance Group to help answer these questions.

Notwithstanding these questions, most members of the Finance Group believe that the overall assessment of The Lewin Report rings true: Medicaid payments to hospitals, in the aggregate, are too low.

Short Term Intervention: Additional Funding for Hospitals

Although the questions outlined above should be answered, the Finance Group believes that the state should not wait for the answers to those questions before revising upward Medicaid funding for hospitals. Vehicles for additional funding, as outlined in previous Finance Group reports and Health Care Task Force discussions, include Medicaid rate increases--either across-the-board or focused on certain hospitals -- relief through the Uncompensated Care Pool, and grants or loans targeted to distressed hospitals – each of which would result in a different distribution of funds. As noted above, Finance Group members disagree about how additional funds should be distributed.

[2] This language appears in the annual state budget appropriation for the Division of Medical Assistance.

The answer to the question of how to distribute additional funds depends on the policy goals that are considered most important. Some of the goals relate to the Medicaid program in particular, while some relate to more general state policy; there is considerable overlap in the interests of the Medicaid program and the state more generally. Members of the Finance Group believe that the following goals are important, but disagree about the emphasis that should be placed on each:

- Fair Payment: Medicaid payment for a particular service should cover a reasonable percentage of the necessary cost of efficiently delivering that service.

- Medicaid Access Preservation: The state's Medicaid policy should work to ensure reasonable access to services for and by Medicaid enrollees. A particularly challenging issue in this context is structuring payment policies that will preserve access to mental health services for Medicaid enrollees.[3]

- System Stability: The state should work to preserve and stabilize the health care delivery system in this time of financial difficulty. This goal does not mean preserving all existing hospitals and their service mixes, but instead means preserving a system that includes those hospitals and services necessary to protect the health of all Massachusetts residents.

The Finance Group believes that there is considerable overlap between the Medicaid goals – fair payment and access preservation – and the broader state goal of system stability. This is especially true in light of recent expansions in Medicaid eligibility, such that Medicaid now covers approximately 15% of the state's population. Moreover, even where a particular strategy may serve the broader goal of system stability more than specific Medicaid goals, the state has an interest in using the Medicaid program as a positive force, both because it is the single largest state health financing fund and because the federal government shares half the expense. Still, it is unlikely that there will be uniformity in Medicaid goals and the broader state goal of system stability. For example, the Finance Group and others have pointed out that some urban community hospitals face particular financial difficulties related to their loss of patient volume to nearby teaching hospitals over the last several years and the fact that they do not enjoy the benefits of a specialized governmental revenue stream such as graduate medical education payments or disproportionate share payments. The state may have an interest in preserving some of these hospitals as a lower-cost setting for care, even if they do not all provide services to significant numbers of Medicaid enrollees. .

Finance Group members believe that, given the focused definition of "fair payment" as stated above, that goal is a "must" and should be attained, even if it requires several years. But, at least in the near term, system stability and access preservation are perhaps more important. Accordingly, some Group members believe that additional Medicaid or other funds, in the near term, should be devoted entirely to targeted assistance for

[3] The Finance Group has begun a discussion of mental health issues and believes they are worthy of separate study and consideration.

hospitals in financial distress that are needed to preserve "system stability," and to those hospitals that are most important to Medicaid enrollees.

The majority of the Finance Group members, however believe that Medicaid is not a grant program, and that its payment policies should be designed to meet, over the long run, the goal of fair payment for services. As such, fair payment is as important as the other goals and may be key to the long-term stability of the system and to preserving access for Medicaid enrollees. As a result those Finance Group members believe that some additional funding, even in the near term, should be devoted to across-the-board Medicaid payment adjustments such as an increase in the inflation factor. This would be in addition to mechanisms that would help hospitals without regard to their Medicaid volume (such as relief of hospitals' contributions to the Uncompensated Care Pool or targeted distress relief grant or loan programs) and those that would help hospitals most important to Medicaid enrollees.

One option would be to develop a multi-year plan that includes some yearly across-the-board increases to make up for the past inflation underpayments combined with limited extra Medicaid payments emphasizing system stability and access preservation. An advantage to this approach is that it would provide immediate assistance to help stabilize all hospitals, and would allow time for further analysis of the questions raised by the Lewin Report to inform broader Medicaid payment policy changes.

In addition, all The Finance Group members believe that regardless of how it is distributed, any additional Medicaid or other funding should be combined with measures designed to address the fundamental problem of "System Inefficiency" as discussed below.

Systemic Problems and Policy Options for the Long Term

Looming even larger than questions the Lewin Report raises about Medicaid payment policy are questions about the structure and culture of the health care system in Massachusetts. These questions flow naturally from observations included in the Lewin Report and from previous reports of the Finance Group that while most of our health care institutions report financial difficulties, Massachusetts still spends more per capita on health care than all but a very few states. The reasons for this, in part, result from the following:

- We utilize hospital outpatient departments at a rate that significantly exceeds the national average.

- We use teaching hospitals at a rate that significantly exceeds the national average.

- We have more physicians per capita than most other areas and the highest proportion of those trained as specialists.

The implication from these observations, taken together, is clear: we must either pay significantly more for our current system of health care – through the Medicaid program, through our private insurance premiums, or both – or we must change the way we provide and receive health care to reduce the aggregate costs and increase the overall efficiency of the system. In fact, the Finance Group believes that we will need to do both if we are to preserve the achievements Massachusetts has made in expanding access, reducing the numbers of uninsured residents and maintaining the quality of care we enjoy.

Some Finance Group members believe that fundamental reform of the system is required, and that no additional money should be devoted to "business as usual." To do this we need to create a much stronger state planning and oversight system and any additional state funds should be consistent with the plans it produces. The majority of the Group believes, however, that while changes and interventions to increase the efficiency of the system as a whole are appropriate, aggressive government intervention may not help the situation or may create new problems. Overall, however, Group members agree that the traditional debate over whether "to regulate or not to regulate" is less helpful than evaluation of particular strategies and policy options that will help reduce aggregate costs and increase overall efficiency of the system. Finance Group members do not necessarily favor all the options listed below, but believe all merit discussion.

Re-distributing care to lower-cost appropriate settings. Finance Group members agree that, in general, the efficiency of the hospital system would be enhanced by <u>some</u> redistribution of care (i.e., more routine and primary care should be delivered at lower-cost community hospitals, health centers and physician offices). Although these changes, in theory, could arise from private sector innovations alone, history suggests that they have not been effective. It may be necessary in the future for state government to assist private sector initiatives (including those developed by other third party insurers) to restructure somewhat the structure and composition of the health care system of the Commonwealth. Policy options that could help encourage this kind of redistribution of care include:

- <u>Consumer incentives</u>. Private insurance products that place on the consumer the financial burden of additional costs associated with the use of high-cost settings where lower-cost settings *are available and clinically appropriate* may help in redistributing care. If consumers choose to obtain routine care at high-cost teaching hospitals where lower-cost settings are geographically available and clinically appropriate, the additional cost would be recognized as a consumer choice, rather than a necessary cost of care to be borne by the insurance system. Similar incentives could be developed to refocus some of the care received by Medicaid recipients. Some Finance Group members are concerned, however, that such incentives could lead to a situation in which only those without financial resources, particularly Medicaid enrollees, obtain care at lower-cost settings; they fear that quality of care in those lower-cost settings may not receive appropriate support if most or all patients

have limited financial resources. They also fear that such a system may be extremely difficult to administer fairly, particularly for lower-income residents.

- State Financial Incentives for Lower-Cost Providers. Low-interest loans or grants from the state to lower-cost providers, including physicians in private practice, to help them enhance access or improve quality of care (e.g., through implementing computerized physician order entry systems) could help address concerns that quality of or access to lower-cost providers is not sufficient to sustain the redistribution of care suggested above.

- Payment Policy and Program Design Changes. For the Medicaid program and private payers, this strategy could include increased provider payments where current payments do not cover reasonable costs of the lower-cost appropriate setting, but restrictions on the extent to which high-cost providers may provide what would otherwise be low-cost care. Of course, access to quality services would have to be assured before any limitations on coverage of particular provider services could be implemented.

- Increased regulation of service mix or payment rates. The state could, by regulation, mandate that all or a portion of routine and primary care be provided in lower-cost settings and that only complex care be provided at higher-cost settings, as clinically appropriate. Alternatively, or in addition, the state could regulate payment rates of Medicaid and private payers to ensure that across the board, payment is made only for the necessary costs of lower-cost clinically appropriate providers. While some members of the Finance Group believe that more regulation is appropriate, most members do not favor a comprehensive regulatory approach.

Establish an independent commission to monitor continuously financial conditions in the health care sector, to report regularly on those conditions, and to recommend reasonable inflation factors for payers to use in updating provider payment levels. As previously suggested by the Finance Group, such an independent commission would not have regulatory authority, and would be separate from existing regulatory agencies. The Health Care Task Force has already highlighted the importance of reporting on financial conditions of health systems. In some ways, establishing an independent commission would carry that function forward after the Task Force comes to a close. (It is possible that such a Commission could be established and financed by non-governmental organizations provided they are not related to the providers or payers of care) Adding an annual report on inflation factors would be a way to encourage rate adjustments based on a common understanding of facts, while still allowing payers flexibility.

State Identification of Needed Hospitals. Some Finance Group members believe that government should determine which hospitals (and other providers) are needed to protect the health of the public, and should take steps to preserve those hospitals and other providers. The failure of health planning activities of the 1980s that were designed to identify hospitals that should be closed may not be indicative of the value of an analysis focused on deciding which hospitals should remain open. Also, once the state identifies

needed hospitals, it would be in a better position to design a Medicaid rate system that supports those classes of hospitals. Other Group members doubt the ability of government (or others) to make such determinations. Nevertheless, agency coordination in planning, policy-making and problem solving has already increased since the establishment of the Task Force, particularly around distressed nursing homes and hospitals. Such increased coordination is appropriate and will help the state determine when intervention may be appropriate to preserve a necessary provider.

Increase state oversight of and intervention in facility operations, possibly including technical assistance and short-term financial support for needed and vulnerable hospitals. Some Finance Group members believe that hospital costs are higher than they need to be, and that the state should play a leadership role in identifying "best practices" that should be implemented to increase efficiency and decrease costs (and which practices unnecessarily increase costs) at the facility or health system level. Other Group members doubt the state's ability to add value in this manner. Many Group members agree, however, that some form of receivership authority or emergency financial assistance, with some degree of management oversight, should be explored and may be required to prevent the loss of important low-cost providers in the near term.

In connection with the above policy options, consideration must be given to the role that our health care system plays in the Massachusetts economy. While much of our state economy is related to health care, high health care costs have the potential to drive some businesses away from Massachusetts. Government intervention and failure to intervene will each have consequences for the economic base of our state.

Many of these options have been outlined in previous Finance Group reports. While discussion at the Task Force has illuminated some concerns about, and some support for, various options, a full discussion of the observations listed above and the possible responses has yet to occur. The Finance Group hopes that, in discussing the Lewin Report, the Task Force will also engage in a discussion of whether fundamental change in our health care system is needed or not, and of which policy options seem most promising.

Attachment 1

Average Medical Assistance Spending per Enrollee by State in 1998

(Includes all Medical Expenses and Long Term Care) 1/ 2/ 3/

Rank	State	Average Expense per Eligible	Rank	State	Average Expense per Eligible
1	NEW YORK	$8,825	27	NEVADA	$5,082
2	NEW HAMPSHIRE	$8,377	28	MICHIGAN	$4,926
3	NORTH DAKOTA	$7,547	29	NORTH CAROLINA	$4,746
4	CONNECTICUT	$7,458	30	KENTUCKY	$4,600
5	RHODE ISLAND	$7,457	31	OREGON	$4,558
6	WISCONSIN	$6,564	32	HAWAII	$4,433
7	**MASSACHUSETTS**	**$6,523**	33	WEST VIRGINIA	$4,421
8	NEW JERSEY	$6,479	34	ARKANSAS	$4,401
9	MAINE	$6,463	35	LOUISIANA	$4,341
10	MINNESOTA	$6,438	36	MISSOURI	$4,319
11	MONTANA	$6,126	37	ILLINOIS	$4,413
12	DISTRICT OF COLUMBIA	$6,014	38	TEXAS	$4,287
13	WYOMING	$5,862	39	FLORIDA	$4,282
14	SOUTH DAKOTA	$5,826	40	WASHINGTON	$4,168
15	KANSAS	$5,804	41	OKLAHOMA	$4,074
16	COLORADO	$5,731	42	VIRGINIA	$4,007
17	OHIO	$5,691	43	NEW MEXICO	$3,940
18	PENNSYLVANIA	$5,660	44	ALABAMA	$3,888
19	ALASKA	$5,638	45	ARIZONA	$3,792
20	IOWA	$5,546	46	MISSISSIPPI	$3,754
21	IDAHO	$5,542	47	VERMONT	$3,495
22	MARYLAND	$5,433	48	SOUTH CAROLINA	$3,443
23	INDIANA	$5,412	49	GEROGIA	$3,356
24	NEBRASKA	$5,350	50	TENNESSEE	$2,959
25	UTAH	$5,233	51	CALIFORNIA	$2,777
26	DELAWARE	$5,110	TOTAL US		**$4,820**

1/ Number of Enrollees computed on an average monthly basis.

2/ Includes spending for all medical services and long term care and excludes DSH payments. DSH payments were excluded because of the wide variation DSH payment amounts across states.

3/ Includes inter-governmental transfers.

Source: Lewin Group analysis of the HCFA 2082 and HCFA 64 forms for 1998.

Average Medical Assistance Spending per Enrollee by State in 1998

(Excludes LTC Services) 1/ 2/ 3/ 4/

Rank	State	Average Expense per Eligible	Rank	State	Average Expense per Eligible
1	NEW YORK	$5,561	26	HAWAII	$3,121
2	RHODE ISLAND	$4,439	27	OHIO	$3,084
3	ALASKA	$4,378	28	INDIANA	$3,073
4	MAINE	$4,329	29	FLORIDA	$2,999
5	**MASSACHUSETTS**	**$4,209**	30	ARKANSAS	$2,974
6	NEW HAMPSHIRE	$4,129	31	WEST VIRGINIA	$2,973
7	DISTRICT OF COLUMBIA	$4,119	32	TEXAS	$2,959
8	NAVADA	$3,878	33	NEW MEXICO	$2,893
9	NEW JERSEY	$3,858	34	KANSAS	$2,862
10	MONTANA	$5,853	35	WASHINGTON	$2,823
11	MARYLAND	$3,780	36	PENNSYLVANIA	$2,821
12	UTAH	$3,753	37	ILLINOIS	$2,798
13	IDAHO	$3,609	38	NEBRASKA	$2,788
14	COLORADO	$3,466	39	LOUISIANA	$2,765
15	CONNECTICUT	$3,451	40	WYOMING	$2,734
16	MICHIGAN	$3,399	41	MISSISSIPPI	$2,614
17	KENTUCKY	$3,352	42	MISSOURI	$2,593
18	WISCONSIN	$3,343	43	VIRGINIA	$2,577
19	IOWA	$3,334	44	ALABAMA	$2,469
20	DELAWARE	$3,294	45	GEORGIA	$2,445
21	NORTH DAKOTA	$3,244	46	OKLAHOMA	$2,348
22	MINNESOTA	$3,187	47	SOUTH CAROLINA	$2,325
23	NORTH CAROLINA	$3,173	48	CALIFORNIA	$2,252
24	OREGON	$3,126	49	VERMONT	$2,182
25	SOUTH DAKOTA	$3,128	50	TENNESSEE	$2,143
				TOTAL US	**$3,135**

1/ Number of Enrollees computed on an average monthly basis.
2/ Includes spending for medical expenses excluding long term care and DSH payments.
3/ Includes inter-governmental transfers not associated with long term care.
4/ Excludes Arizona, since all services in that state were capitated, including long term care.
Source: Lewin Group analysis of the HCFA 2082 and HCFA 64 forms for 1998.

Table 1.1
Medical Assistance Beneficiaries and Uninsured Persons as Percent of Residents

State	Uninsured	Medical Assistance
NY	17.1%	19.3%
MA	**11.1%**	**15.5%**
RI	9.0%	15.1%
IL	13.8%	14.8%
PA	10.0%	14.3%
MI	12.0%	13.8%
OH	11.0%	12.5%
CT	11.5%	12.3%
NJ	15.4%	10.6%
IN	12.2%	10.3%
WI	10.3%	10.3%

Sources: U.S. Bureau of the Census, State Population Estimates for July 1, 1998
HCFA, Medicaid Statistical Information System, HCFA-2082 forms
U.S. Bureau of the Census, Health Insurance Coverage, Sept. 2000, 3-year average (1997-1999)

The Lewin Group, *Analysis of the Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers,* June 2001.

Table 1.2
Characteristics of Hospitals in Benchmark States

	Number of Acute Care Hospitals	% of Hospitals with Teaching	% of Hospitals that are Rural	% of Hospitals with Beds <100	% of Hospitals with Beds >500	Medicaid Cost % of Total Cost	Medicaid Payment to Cost Ratio
Connecticut	31	52%	19%	26%	10%	11.4%	0.74
Illinois	201	31%	37%	31%	6%	11.5%	0.74
Indiana	108	19%	43%	50%	7%	8.9%	0.95
Massachusetts	**71**	**44%**	**15%**	**23%**	**8%**	**9.6%**	**0.77**
Michigan	144	28%	41%	51%	6%	9.1%	0.95
New Jersey	74	59%	0%	4%	14%	8.7%	0.92
New York	213	56%	18%	16%	16%	24.3%	1.06
Ohio	166	37%	31%	34%	8%	10.0%	0.93
Pennsylvania	191	46%	24%	20%	8%	8.0%	0.77
Rhode Island	11	36%	9%	18%	9%	9.4%	0.99
Wisconsin	125	8%	53%	49%	2%	6.9%	0.78

*Includes acute care hospital data only
** Medicaid cost % of total cost and Medicaid Payment to cost ratio is based on reported hospital data only
Source: The Lewin Group analysis of 1999 AHA Annual Survey data.

The Lewin Group, *Analysis of the Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers,* June 2001.